INDIVIDUAL STUDY

Antenatal memories and psychopathology

ROGER NEIGHBOUR, MA, MB, MRCGP
General Practitioner, Abbots Langley, Herts.

SUMMARY. A case is described of suicidal impulses apparently stemming from the patient's experience before and during his birth. By using a technique of 'rebirthing', antenatal memories were relived and their traumatic effects resolved. Theoretical and practical accounts of rebirthing are given, and its significance for general practitioners is discussed.

Introduction

THIS is an account of a search for the origins of one young man's attempted suicide. It is also a first-hand account of how I, as his general practitioner, found myself accompanying him into unfamiliar psychological territory, the negotiation of which brought about the extension of my own thought, skills and experience in ways I value and commend to others. I should like to claim for it the status of a research report—not the orthodox experimental research of the uninvolved observer seeking objective and reproducible evidence of causality, but 'experiential research' (Heron, 1971). In research of this kind the experimenter explores the inner world of his relationship with another person in ways validated primarily by the two of them and only secondarily accessible to others, who may in turn choose to subject themselves to the same process of enquiry.

Case presentation

One afternoon in November 1979 'Ian G.', aged 18, slashed his wrists. Intent upon death, he made some superficial cuts with a kitchen knife at home, but, anticipating that the mess would cause further horror for his family, he then took himself off to a nearby wood. He made his way to the thickest part, lay down against a fallen tree-trunk and cut his wrists again. The pain from the gashes was unexpectedly great and stopped him cutting deep enough to sever an artery; he then returned home bleeding and was discovered by his younger brother. He was brought to the surgery, where I sutured the wounds.

My initial conversations with Ian and his parents produced few clues to any psychopathology. Ian is the middle one of three sons in a well-integrated family previously unknown to me. After leaving school he had attended art college, but had become disenchanted with it and was about to start work in a department store. There seemed to have been no recent emotional crisis, and although his family had lately found him rather preoccupied, they had no inkling that a suicide attempt was imminent. There was no evidence of psychotic thought or of features on which to base a formal psychiatric diagnosis as a useful prelude to therapy. Neither could I find any of the usual well-documented causes of adolescent depression such as problems of self-image, identity, sexuality or relationships. The closest Ian could come to explaining his motives was that he felt—had always felt—out of place in the world; that his death was inevitable, desirable and long overdue; that he still felt impelled to die but was now held back by knowledge of the grief it would cause his family, and that the best way for me to help was to ease this guilt to less paralyzing intensity so that he could die untroubled.

Initial approaches

Ian and I quickly established a working rapport and arranged regular times for psychotherapy. He soon withdrew from all social contact except with his immediate family and myself.

My own informal training in psychotherapy includes five years of Balint-type seminars, with some experience of small group and family therapy, Transactional Analysis, and more recently espousal of the humanistic psychology movement (Rowan, 1976). Underlying these different methodologies is a broadly 'developmental' model, with its axiom that our experience of the past patterns our awareness of the present. The human condition brings experiences of pain, loss and oppression which are inherently distressing. Distress, if not appropriately expressed and attended to at the time, is stored and can distort later motivation and feelings and jeopardize the fullest growth of the personality. However, memory allows us a second chance. We can gain access to past distress either by inference when we

recognize its resonances in present thought and behaviour (which is the approach of psychoanalysis), or by using regression and cathartic techniques to relive and rework traumatic reactions in a supportive setting.

Trawling the diagnostic net through Ian's remembered past produced little of consequence. His medical history was sparse, except for a tonsillectomy at the age of four which with some prompting he would describe as upsetting: "a mask is lowered on my face, making me panic." His childhood had been free of emotional trauma, yet he could recall inexplicable feelings of being alone in a hostile world as early as age three or four.

Over several weeks I had regular joint meetings with Ian and his parents. These sessions were useful in dispelling some of the family's guilt and anxiety and in confirming their caring and supportive roles. Mr and Mrs G. were perturbed to hear their son trace his preoccupation with dying back to early childhood. Interplay between the three remained superficial, however, and family dynamics seemed irrelevant both to the origin of Ian's sense of alienation and to the timing of the suicide attempt.

Gradually the flavour of the individual sessions changed. Ian reported frequent feelings of sadness and, more surprisingly, unaccountable fear. He became afraid of the dark and of being alone. He seldom left the house. He mistook shapes in his bedroom at night for frightening human figures, and was occasionally found hiding behind doors or in a wardrobe.

One dream from this period is worth giving in detail. He was alone in a room at art school. He looked out of the window and saw people coming back to get him. Turning round, he saw one of his tutors, dressed in black, trying on a white hat in a mirror. He thought the man was Death, and was frightened. Then he felt himself falling backwards, moaning. There was a prickly sensation inside his head. He felt he was going somewhere, going to die, and the man was going to help him. Then he awoke, feeling afraid of the dark.

At the time, I thought this was a dream of his tonsillectomy. I now believe it is a transformed birth memory.

I was becoming frustrated and rather angry at the lack of progress. None of the case material seemed to carry sufficient emotional charge to energize Ian's urge to be dead. Discussing this feeling of impasse with Ian one day, I noticed a change in his manner. He said he too felt 'stuck'. His voice tailed off, he drew his knees up to his chest, and his head inclined more and more to the left until his ear was almost down on his shoulder. Something infantile about his demeanour made me ask, "How old do you feel right now?", and immediately came the reply, "No age at all."

I had reached a point with Ian which, it occurred to me, was like delay in the second stage of labour—much pushing but no progress. Indeed, when I first put it to him that it was as if he had not yet managed to be born, Ian was quite taken with the notion. It appeared to have more than surface meaning for him, and, uncharacteristically, he afterwards discussed it with his family.

Rebirthing—theory and techniques

There is a saying in Zen that "when the pupil is ready, the master appears". At about this time I was introduced through reading and personal contact to the idea that obstetric descriptions of a psychological state can have more than metaphorical truth and in fact be rooted in ontogenetic reality. Behind terms like 'natal therapy', 'rebirthing' and 'primal re-integration' there is a body of theoretical constructs, clinical evidence and therapeutic techniques relating to one basic hypothesis, namely that the fetus's experiences before and during birth are formatively incorporated into its emergent personality. The intrauterine environment can exert at least as powerful an effect on the child's psychological development as the better understood post-natal influences (Emerson, 1979; Lake, 1979; Feher, 1980).

Stanislav Grof (1975) has described a classification of the feelings and images re-experienced when subjects are regressed to periods before and during birth. He aggregates this material around four themes called Basic Perinatal Matrices (BPMs I-IV), corresponding to successive physiological phases of pregnancy and birth. The baby's experience within each matrix becomes a psychological template, moulding the structure and development of the unconscious mind and colouring the way subsequent life events are perceived. Grof gives the name 'COEX—System' (System of COndensed EXperience) to the constellation of memories, feelings, behaviour and personality traits elaborated post-natally upon some aspect of the birth trauma.

BPM I covers the period from conception to the onset of labour. In reliving a 'good' pregnancy, the subject-as-fetus may experience feelings of ecstasy and belonging, of being welcomed, nourished and satisfied. The converse impression of being in a 'bad' womb may be felt as rejection, hatred, paranoia or isolation, and can be caused, for instance, by placental insufficiency, threatened miscarriage, or by toxins such as alcohol or tobacco flooding into the fetus via the umbilical vessels. The mother's emotional state, mediated by circulating catecholamines, enkephalins or other neurochemical transmitters, is communicated to her baby as 'umbilical affect'—love or rejection, joy or guilt, coursing through the cord into an impressionable embryo.

BPM II is the first stage of labour, a 'no exit' phase in which a previously calm womb becomes confining and turns vicious, with increasingly powerful uterine contractions squeezing the child relentlessly against a closed cervix. Rebirthing subjects in BPM II may feel anxiety, fear, resentment, helplessness, anger, betrayal or worthlessness, feelings which may be re-awakened in later life when a hitherto secure environment or relationship lets them down.

BPM III relates to the second stage of labour, a time

of struggle and upheaval, movement and progress at last. It is common for the subject-as-fetus to feel pain and pressure around the head and involuntarily to re-enact the physical process of delivery, including internal and external rotation of the head. The emotions of BPM III can range from pride and exhilaration through panic or suffocation to blind terror. I consider that Ian's fetal posture, the tilted head and 'stuck' feeling described earlier, were components of a COEX—System based on the transition from BPM II to III.

BPM IV is the third stage of labour, reception into a different world of intense stimulation. The cord is cut, and breathing and independent life begin. At this stage in the birth regression, subjects may recapture peace, love and acceptance or they may experience outrage, bewilderment and alienation. BPM IV can include the baby's reaction to breech, forceps or caesarean delivery.

The aim of rebirthing, as with any cathartic technique, is to enable an informed and willing subject to relive and abreact traumatic perinatal experiences in a safe setting, allowing accumulated distress to be discharged. The therapist helps the subject to become aware of birth experiences and helps him or her to express uninhibited reactions. During the session, the subject's attention oscillates, sometimes becoming absorbed in the regression and at others returning to the present and keeping a critical adult perspective on the rebirthing process. The facilitator invites the subject to remain open to any images, sensations, emotions and muscular tensions that arise, and to react with words, body movements and noise. He or she contributes non-verbally by simulating, say, a birth canal with the hands or knees, a uterine fundus by constraining the subject's legs in flexion, or an umbilical cord by resting a hand gently on the subject's navel and transmitting a rhythmic 'lub-dup' with slight finger pressure. The session needs to be unhurried, ending when the subject chooses or feels it to be complete. The subject then needs time to talk about the experience and to relate its meaning to his or her life situation.

Ian's rebirthing

I suggested to Ian, with some trepidation, that his state of mind and our therapeutic impasse might be amenable to rebirthing, which I described as explicitly as I then could. My idea at the time was that his negativism might stem from a BPM IV perception of the extra-uterine world as intolerably hostile.

First session

Having arranged mattress and pillow for Ian to lie on and for me to sit on alongside, I began by taking him through a relaxation routine of tensing and relaxing muscle groups in ascending sequence from toes to face. Then to start the regression I used a technique of 'guided fantasy', in which I suggested that he see himself in his mind's eye taking a walk from a pleasant outdoor scene into a cave (symbolizing the uterus), whose walls gradually closed in to form a narrowing passage (birth canal) through which he would have to squeeze and which seemed to come to a dead end.

Within a few minutes Ian's legs became restless and progressively flexed. His arms grew fidgety and he drew them tight across his chest; then, in spontaneous response to a gentle rhythmic impulse from my hand over his umbilicus, he abruptly turned onto his left side into a typically fetal position. He said he felt anxious and afraid, and began to burrow his head down into the pillow. With pressure from my hands on his head I supplied a 'cervix' for him to push against, which he did intermittently, grunting with increasing effort. At one point he began hitting with his hands a spot on his forehead above the left eyebrow, saying it had become painful. My touching this spot made him try to push me aside with considerable force, aided by extensor thrusts of the legs. He overcame my hands' resistance with one last heave, then his attention disengaged from the birth re-enactment and the session seemed to both of us to be complete. It had lasted about an hour.

I think this session saw the resolution of a COEX—System based on BPM III, where Ian felt stuck but was able to force a way out. Afterwards, neither of us felt therapeutically stuck any more; we seemed at last to be reaching relevant levels of the psyche and agreed to continue the rebirthing sessions once or twice a week. For later sessions we dispensed with the guided fantasy, as Ian needed only to lie down, close his eyes and breathe deeply for profound regression to occur.

Second and subsequent sessions

In the second session Ian quickly assumed a fetal position and regressed to a state he described as 'peaceful'. Soon, however, he became agitated, experiencing pain in the stomach and nausea. I asked him to position my hand at the source of the discomfort. He put it to his navel. Then a look of alarm flashed across his face and he began to move about the floor, clawing my hand away from his umbilicus. I held and reassured him until the distress subsided, but he said afterwards that he had been very frightened, and for several days following he had the feeling that there was someone malevolent lurking in dark corners at home.

The third session recapitulated the second, Ian again receiving a surge of something sickening and frightening through the umbilicus. This time, however, he went on to unleash a frenzy of terror and panic. With loud cries he threw himself about the room, tearing up carpet tiles and knocking books off the shelves. Again and again he made violent two-handed stabbing movements directed at his navel, like hara-kiri. His voice changed, and he began to talk unusually fast in a Scottish accent, saying his name was Fergus and insisting "Don't call me Ian!" He remained in this state for over two hours. I phoned his parents to take him home, where, largely for my own peace of mind, I sedated him with intravenous proma-

zine. (This was the only occasion when I gave him medication.) The next day he was his usual self again, with full recall of the previous evening's session.

This session, with its tremendous energy, was crucial. Ian-as-fetus received a sudden umbilical influx of terror and tried desperately to escape it, attacking his navel and even denying his own existence by adopting another persona, 'Fergus'. The next few sessions were also full of fear and violence. The target area for his self-mutilating gestures spread peripherally to chest, back and limbs as Ian acted out fantasies of being shot to pieces and having his hands and feet lopped off by unseen assailants.

I questioned Ian's mother. She described her pregnancy as uneventful—she had been well, he was a wanted baby. Then, unprompted, she recalled at about four months witnessing a road accident which had badly scared her. My hypothesis is that adrenalin from her own sympathetic nervous response had flooded her unborn child with second-hand fear. This infusion with inescapable bad blood initiated a COEX—System which culminated 18 years later in an almost literal re-enactment as Ian nestled in a thick wood (womb) against a dead tree-trunk (cord) and cut his wrists to bleed away his intolerable alienation. Is it coincidence that Ian has several small, red birthmarks on his fingers resembling splashes of blood?

In retrospect I recognized other components of this COEX—System. 'Fergus' was a character in a game of funny voices Ian and his brother played as children. Being shot had been a childhood game as well. Ian showed me a small picture he painted several years ago, of a frightened figure with a severed hand, rooted to the ground under a street-lamp. In the enclosing darkness were many malevolent eyes.

Resolution

The violence subsided over the course of several rebirthing sessions. Ian started to experience increasing spells of untroubled peace. One session, which I found very poignant, he spent mainly in BPM IV. He said he felt peaceful and safe, and any mother of a new-born child would have recognized his expression of unblinking serenity.

As in sessions the birth trauma resolved, so Ian's mood and behaviour altered. He started going out and renewing old friendships. He took up drawing and playing the guitar again and formed a small rock band. He now says he feels more positive, glad to be alive and free from suicidal impulses. Family and friends have independently expressed pleasure at the sustained change.

Discussion

To have accompanied Ian in his odyssey and seen him emerge transformed—reborn—has been rewarding and often moving. Is the change due to the therapy, or would he have matured anyway in six months? Is this just a 'transference cure', an epiphenomenon of the doctor–patient relationship, not related to its overt content? Clearly, controlled trials and the experimental method are inappropriate. I can, however, vouch for the authenticity of the experiences I have described, confirm that they have meaning for the two of us involved, point to the outcome and invite others to explore in the same way.

Are the scenes evoked really memories, and, if so, how does the fetus retain them? William Emerson (1979) has researched this by checking retrospectively on the obstetric histories of his rebirthed subjects, especially in cases where obstetric facts had not previously been conveyed to the subject. He has found an extremely high correlation between documented events in pregnancy and labour and the rebirth descriptions. As to mechanism, while admitting ignorance, one can acknowledge that memory and mood are probably partly biochemical, mediated by RNA, polypeptides and neurotransmitters as well as being neurologically based. Indeed, it would be odd if the central nervous system was unique among fetal tissues in failing to achieve a degree of functional maturity before birth.

I felt it was important to experience rebirthing first-hand, so I went to a birth re-enactment workshop at the Human Potential Research Project, University of Surrey. Two themes emerged during my own birth work, a BPM I state of delightful weightlessness and self-sufficiency, and BPM III feelings of alternating fury and despair while struggling to be delivered. These connect significantly with my present-day interests, behaviour and personality.

If rebirth phenomena are even only partly what they seem, how much greater responsibility does a woman's physical and emotional well-being during pregnancy assume for the happiness and stability of her child? One could argue that Leboyer (1975), in urging more decorous and sensitive childbirth, does not go half far enough. To the extent that the fetus registers its mother's states of body, mind and attitude, parenting could be said to start from conception. Major opportunities for preventive psychiatry may lie in the management of threatened abortion, placental insufficiency, premature and prolonged labour, caesarean section, unwanted pregnancy, maternal drug-taking, smoking, depression, rejection, anxiety and so on.

'Metaphorical' diagnosis

The general practitioner already makes diagnoses in physical, psychological and social terms (*Royal College of General Practitioners,* 1972). I want to suggest that to this triad be added a fourth category, that of diagnosis in metaphorical terms. Attention to whole-person medicine should make us ask, "What meaning does this illness have for the individual?" Symptoms can variously symbolize the end of youth, a child-like need for protection, defeat with honour and so on. This meta-

phorical aspect of disease is implicit when we see people with apparently psychosomatic symptoms and ask, for instance, the neurodermatitis sufferer what has got under her skin, or the asthmatic what he feels choked about, or the dyspeptic who he is sick of, or the agoraphobic what relationship she feels trapped by. Spotting the metaphor can give insight into the time and circumstances when the patient failed to cope with some stress.

I suggest that an important feature of intuitive medicine is an ability to make metaphorical 'as if . . .' hypotheses connecting patterns and themes in a patient's behaviour and feelings with some model of human development. Grof's Basic Perinatal Matrices offer a physiologically-based framework for interpreting many symptom clusters and behaviours as 'birth metaphors'. The feel of situations and relationships one keeps getting into may recapture qualities of the primal context, the womb (Laing, 1976). Inexplicable feelings and reactions under stress and conflict may reaffirm old memories of labour and delivery, and so on.

Asked whether this type of work falls within the domain of general practice, I would make comparisons with individual and group psychotherapy, counselling, hypnosis, behaviour therapy, psychosexual counselling, marital and family therapy. All these are skills which were once the prerogative of specialists, but which many general practitioners have learnt and now include in their repertoires, to their own and their patients' satisfaction. A coherent conceptual framework can subserve a wide spectrum of therapeutic commitment, from a completely self-contained programme of therapy to the occasional insightful remark dropped into a consultation as a seed around which meaning can crystallize. I have witnessed with Ian the incarnation of metaphor, and in the privileged loneliness of the consulting room have seen made tangible George Santayana's epithet, "Those who cannot remember the past are condemned to repeat it."

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Address for reprints

Dr Roger Neighbour, Argowan, Bell Lane, Bedmond, Herts. WD5 0QS.

Haematocrit, carotid stenosis and cerebral infarction

Carotid angiograms in 187 patients presenting with transient ischaemic attacks and minor completed strokes were reviewed. A haematocrit of 50 per cent or more was encountered more frequently in those found to have carotid occlusion. The severity of vessel-wall disease showed no relationship to the level of haematocrit. Computerized axial tomographic measurements of the volume of the cerebral infarct seen in 23 patients with carotid occlusion and completed strokes showed a correlation between the size of the infarct and the height of the haematocrit. It is suggested that reduced blood flow resulting from increased blood viscosity associated with a high haematocrit adversely affects collateral flow, thereby increasing the size of the infarct.

Source: Harrison, M. J. G., Kendall, B. E., Pollock, S. *et al.* (1981). Effect of haematocrit on carotid stenosis and cerebral infarction. *Lancet,* **2**, 114-118.

Immunization

Review of all 126 children admitted to the communicable diseases unit (in Birmingham) with whooping cough during the epidemic in 1978 showed that two had received two doses of triple vaccine and only one had had full primary immunization against the disease. None of these three children suffered complications of the disease. Of the 123 children who had not been immunized against pertussis, however, 66 had one or more complications.

These findings suggest that the apparently positive decision by parents to omit pertussis immunization was misplaced, since immunization does protect against the more serious complications of the disease. Furthermore, there is no firm evidence that pertussis immunization of children without specific contraindications is associated with serious adverse reactions.

Source: McKendrick, M. W., Gully, P. R., Geddes, A. M. (1980). Protection against pertussis by immunization. *British Medical Journal,* **281**, 1390-1391.